

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

128

PLACE OF DEATH
County Barton
Township Wilford
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 45
Primary Registration District No. 5067

File No. _____
Registered No. 1

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Julius Herman Loebe

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE ☒ MARRIED ☐ WIDOWED ☐ OR-DIVORCED ☐ (Write the word)

DATE OF DEATH January 17, 1916
(Month) (Day) (Year)

DATE OF BIRTH Feb, 1852
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

AGE 63 yrs. 0 mos. 0 ds. If LESS than 1 day, ___ hrs. or ___ min.?

that I last saw h _____ alive on _____, 1916,

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Heart Failure
200A

BIRTHPLACE
(City or town, State or foreign country) Germany

PARENTS
NAME OF FATHER Leone Loebe
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Dora Fleisher
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 1916 (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. H. Loebe
(ADDRESS) Wilford Mo

PLACE OF BURIAL OR REMOVAL St James Cemetery DATE OF BURIAL 1/14, 1916

UNDERTAKER Lee Franklin ADDRESS Wilford Mo

Filed 1/21, 1916 H. D. Wacker REGISTRAR

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

applied. AGE should be stated EXACTLY. PHYSICIANS should state
properly classified. Exact statement of OCCUPATION is very important
CAUSE OF DEATH in plain terms

MASSACHUSETTS STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE
A FEE FOR CERTIFICATES UNTIL THEY
ARE COMPLETED AS PRESCRIBED BY
LAW

1 PLACE OF DEATH
County Boston
Township Melford
or
Village
or
City

Registration District No. 45 File No.
Primary Registration District No. 5067 Registered No. 1
(NO. St. Ward)

[If death occurred in a
hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Julius Herman Lowe

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 SINGLE M
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6 DATE OF BIRTH
(Month) (Day) 1 (Year)
7 AGE
If LESS than
1 day hrs.
or min.?
yrs. mos. ds.
8 OCCUPATION
(a) Trade, profession, or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)
9 BIRTHPLACE
(City or town,
State or foreign country)

10 DATE OF DEATH
(Month) (Day) 191 (Year)
11 I HEREBY CERTIFY, that I attended deceased from
191 (Year)
that I last saw him alive on 191 (Year)
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

Heart Failure!
No attending Physician.
(Duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.
(Signed) J. H. Duquette M. D.
3/2, 1916 (Address) Melford

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,
or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or usual residence.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
20 UNDERTAKER ADDRESS

15
Filed 3/21, 1916 J. H. Duquette
Registrar

Original file, date 1-11, 1916

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
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